



Northeast Health

THE EDDY • ALBANY MEMORIAL HOSPITAL • SAMARITAN HOSPITAL
SUNNYVIEW REHABILITATION HOSPITAL

Albany Memorial Hospital Samaritan Hospital Sunnyview Rehabilitation Hospital

Community Service Plan Comprehensive Three-year Plan September 15, 2009

I. Mission Statement

A. “To provide a high-quality, accessible continuum of healthcare, supportive housing and community services.”

B. The mission statement, adopted in 1998, speaks to the diverse and wide-reaching services provided by Northeast Health, a not-for-profit network comprised of Albany Memorial Hospital, Samaritan Hospital, Sunnyview Rehabilitation Hospital and The Eddy. Serving a 22-county area in upstate New York, Northeast Health services include primary, acute, long-term, adult day, skilled nursing and Alzheimer’s care, as well as rehabilitation, home care, and assisted and independent retirement living. Corporate headquarters are located at 2212 Burdett Avenue, Troy, NY 12180.

The **Patient Care Division** is comprised of **Albany Memorial Hospital**, a 165-bed facility located at 600 Northern Boulevard, Albany, and **Samaritan Hospital**, a 238-bed facility at 2215 Burdett Avenue, Troy. Both are community hospitals with long traditions of caring for the needs of the communities they serve. The hospitals also operate primary care offices (8) throughout the Capital Region, as well as satellite locations for medical imaging, behavioral health services, Healthy Families of Rensselaer County, and the Sexual Assault and Crime Victims Assistance Program.

The **Long-term Division** is comprised of **The Eddy** network of nursing home, community-based care and rehabilitation services, including **Sunnyview Rehabilitation Hospital** in Schenectady which joined Northeast Health in January 2007. Sunnyview Rehabilitation Hospital is located at 1270 Belmont Avenue, Schenectady. The hospital is a 104-bed rehabilitation-only facility. Sunnyview operates satellite outpatient physical therapy centers at 3757 Carman Road, Guilderland, and at Amsterdam Memorial Hospital in Amsterdam.

II. Service Area

- A. Albany Memorial Hospital:** Primary - Albany County; Secondary - Rensselaer County
Samaritan Hospital: Primary - Rensselaer County; Secondary - Albany County
Sunnyview Rehabilitation Hospital: Primary - Schenectady & Saratoga counties;
Secondary - Albany, Rensselaer, Fulton, & Montgomery Counties.

(Sunnyview's service area, as a specialty rehabilitation hospital, extends to 27 counties within upstate New York, western Vermont and western Massachusetts.)

B. For the purpose of assessing community health need, we used the above-mentioned four counties that were in the primary service areas of the three hospitals, namely: Albany, Rensselaer, Schenectady and Saratoga.

The 2008 patient origin discharge data from each hospital was studied to determine what zip codes comprised the primary and secondary service areas.

These areas are then assessed for common characteristics which are then compared to the remaining areas of the region. By doing this, we determined that the entire four-county area is a logical region for assessing need. In essence the areas that were left out were zip code areas largely in suburban and rural areas.

For example, while Albany Memorial and Samaritan's service areas are largely Albany and Rensselaer Counties, the hospitals also draw patients from southern Saratoga County. Albany Memorial also draws patients from northern Columbia County largely because there is a primary care practice in that area.

Focusing on information at the county level for this plan has the following advantages:

- Ease of data collection – More data sources can provide county-level data than is available by zip code.
- The four-county area covers a reasonable mix of populations including urban (three major cities), suburban and rural.
- If there are significant issues uncovered in our analysis, it is always possible to obtain zip code level data to determine which areas of the county are most impacted.

III. Public Participation

Albany Memorial and Samaritan Hospitals, and Sunnyview Rehabilitation Hospital, as components of Northeast Health, participated in a public engagement process coordinated for this region by the Healthy Capital District Initiative. NEH has been a participant in HCIDI since 1999 and serves as a sponsor and Board of Directors member. Other sponsors of HCIDI include all hospitals, County Health Departments and payers in the Albany, Rensselaer and Schenectady County areas. HCIDI undertook a three-pronged initiative to engage the public and assess community need. These three efforts were:

1. The collection and analysis of data in the Community Health Profile – the third update and revision of a document first produced in 2000.
2. The production of a Community Health Forum broadcast by the local PBS affiliate
3. The collection of data via a Community Health Survey that could be accessed via the Internet to assess their opinion on the health of the Capital District.

Each of these methods is described in detail below.

The Profile

The Community Health Profile Report to the Capital District Community and Sponsors is the third data analysis of the health needs in the region over the past ten years. It expands upon the predominantly mortality driven analysis of its predecessor to include hospitalization analyses, including prevention quality indicators, and health behaviors. The structure of this report is founded upon the Prevention Agenda of New York State. Utilizing this framework and these statistical lenses, we will be able to track the need and impact of collective efforts to improve health. This analysis is not completely inclusive of every health condition or public health issue. Individuals working on, or experiencing first hand, a particular health issue will undoubtedly have valuable knowledge to contribute beyond the data available. The analysis completed was chosen based upon the availability of reliable, comparable data and the delineated priority health areas for the New York State Department of Health. The results should provide a clear and fundamental description of the prevalence and concentration of each health indicator included.

The Public Forum

On June 23, 2009, WMHT-TV, in collaboration with the Healthy Capital District Initiative, produced a televised Community Health Forum to provide citizen input to the state-mandated Community Health Assessment. This assessment, including data from local health departments, hospitals and caregivers, combined with anecdotal contributions from patients and their families, was designed to provide a full perspective on local health care needs, which will aid hospitals in developing a Community Service Plan.

The one-hour program featured a studio audience of about 80 public health experts and stakeholders as well as a broad range of consumers from the three counties. Also, call-in questions and comments from viewers were broadcast live from the WMHT studios. The forum was moderated by Benita Zahn, WNYT Health Reporter/Anchor and Host of WMHT's *Health Link*.

On the show, Benita Zahn presented a brief introduction to the program and lead-in to a pre-recorded message from Richard Daines, MD, Commissioner of Health, New York State. Dr. Daines introduced the State's Prevention Agenda and encouraged each community to collaboratively develop local responses to the health issues they find in their community. Kevin Jobin-Davis PhD, HCDI, Executive Director, summarized the process of collecting health data for the four counties and the process and criteria for selecting community priorities.

Throughout the program, audience members (both in the studio and by telephone) were encouraged to ask questions and offer their own personal experiences of seeking and receiving health care in the Capital District.

The discussions and question periods throughout the program were divided into two major regional health issues that have been identified through the data of the 2009 Assessment. The two major issues discussed were access to health care and the impact of chronic disease in our communities. Each of these topics and the following discussion was introduced by short video segments of persons that framed the individual issue.

At the close of the show, the moderator summarized the highlights of the interaction of the studio and call-in audience. Over the weekend, the entire show was re-broadcast on WMHT for those viewers who were unable to watch the show. In addition the HCDI web site made the WMHT program available to those that wanted to review it at a more convenient time.

The Survey

During the show, viewers were continually encouraged to complete a Community Health Survey, using a web-based survey instrument that was available as a link on the WMHT web site, HCDI website and sites of other organizations. Questions on the survey addressed health insurance issues, where people generally went to get health care services, and what types of issues prevented one from seeking health care when they needed it. It also queried people on the types of health services that were needed in their community, use of hospital emergency departments, and prevalence of chronic illnesses in families. Also, each survey participant was asked what he or she personally needed to do in order to be healthier. This data was presented as a section in the 2009 Community Health Assessment. More than 1,100 responses to the on-line survey were received within a three-week period following the WMHT forum.

The survey results were used in the selection of the priorities. Feedback from the survey and the comments written by respondents supported the problems of access, chronic disease and mental illness.

Selected results from the 1,173 respondents are summarized below:

- 1.9 % reported no health insurance
- 9.7 % receive primary care from an emergency room or urgent care center
- 70% reported someone in their household with a chronic disease

The prevalence of responses is as follows:

	PERCENT	NUMBER
High Blood Pressure	56.4%	431
Arthritis/Rheumatism or Other Bone/Joint Diseases	33.8%	258
Depression/Anxiety/Emotional Problem	30.6%	234
Asthma	29.6%	226
Diabetes	25.4%	194
Heart Disease	16.2%	124
Cancer	9.8%	75
Kidney Disease	3.7%	28
Stroke	1.7%	13

Public participation described above was complimented by our interaction with the counties (Albany, Rensselaer and Schenectady) as they conducted their Community Health Assessments (CHA's). As noted above the counties are also active participants in the Healthy Capital District Initiative. Their priorities were shared as the process proceeded. Individual meetings were also held between providers and the counties to review common interests.

In addition to participation in the HCDI and its activities, Northeast Health hospitals also solicit public participation in assessing community need through various other means, including:

- Focus groups/market research
- Press Ganey patient satisfaction surveys
- Board of directors, a community based body of 26 persons
- Advisory boards/committees
- Auxiliaries & volunteers

- Collaboration with community partners, including public and private organizations/associations
- Consumer web site

IV. Assessment of Public Health Priorities

A. Criteria for Public Health Priorities

In reviewing Dr. Daine's ten public health priorities, Northeast Health identified, through the HCIDI process and local efforts to solicit input from the community, the priorities listed below for each of its acute care hospitals.

Additionally, Sunnyview Hospital utilized the Community Health Assessment (CHA) submitted by Schenectady County Public Health Services (SCPHS). This document reflects a collaborative effort through which multiple data sources were analyzed to identify and rank the top health concerns in Albany, Schenectady and Rensselaer Counties.

B. Selected Prevention Agenda Priorities

Albany Memorial Hospital

- Access to Care: Enhance Primary Care Services
- Chronic Disease: Cardiovascular Health (CHF & Stroke), Diabetes
- Samaritan Hospital
- Access to Care: Enhance Primary Care Services
- Chronic Disease: Cancer (Breast and Colorectal)
- Mental Health & Substance Abuse

Sunnyview Rehabilitation Hospital

- Access to Rehabilitative Care
- Chronic Disease: Obesity and Diabetes

C. Status of Priorities

Each of the above-named priority areas represents existing programs that will be supplemented by input and support from community partners, with the possible exception of Behavioral Health's recently started Suicide Program described under the Mental Health and Substance Abuse section for Samaritan Hospital.

D. Non-Prevention Priorities Considered in the Assessment Process

Albany Memorial Hospital

Emergency Department - in early 2009, Albany Memorial unveiled a new 30,000 square foot emergency department to accommodate the dramatic growth and increased care needs in the community. The expanded area features a patient-centered design that can accommodate 40,000 patient visits a year, versus the former ED, which was designed to accommodate 18,000 patient visits each year. The project included centralization of the nurses' station to enhance patient care; bedside registration to streamline admission and promote patient privacy; enhanced security, including the ability to lock-down; additional isolation rooms, as well as a decontamination room to respond to the need for community preparedness.

Wound Center - Albany Memorial is planning an expansion of its wound care center in response to the growing number of patients suffering from chronic wounds caused by diabetes, circulatory and other problems. Patients with diabetes have a 15-fold increase in the risk of amputation. Studies have shown that specialized wound care treatment facilities significantly increase healing rates and reduce amputation rates. The Center for Wound Care and Hyperbaric Medicine provides

a variety of clinical treatments, debridement, medicine, dressings, hyperbaric oxygen treatment (HBOT) and support services that have proven highly effective in facilitating the healing process.

Samaritan Hospital

Prostate Screenings - The Cancer Treatment Center at Samaritan annually holds free prostate cancer screenings for men 50 - 75 years of age, or men over 45 with a family history or of African/American descent. Screenings include both a PSA and physical exam. Patients are referred to a specialist, if needed.

Sexual Assault and Crime Victims Assistance Program - The Sexual Assault and Crime Victims Assistance Program for Rensselaer County, located at Samaritan, is committed to reducing the trauma of sexual assault, crime, and violence, as well as providing community education for its prevention. The center, in existence since 1979, is dedicated to creating a supportive, caring environment for victims/ survivors and their families to enhance the healing process. It is the only agency in the county providing comprehensive, specialized services to victims of sexual violence, victims of stalking, older adults, homicide survivors, as well as other victims of crime, their family members and friends, or significant others. In addition, the program holds numerous outreach programs for school-aged children.

Healthy Families - Healthy Families of Rensselaer County, located at Samaritan Hospital, has been serving families since 1994 with an assessment and referral service, as well as a home visiting service. The goal is to support parents and to help them feel confident and enthusiastic about their role as parents. The program collaborates with area hospitals, doctors, schools and community organization. Healthy Families of Rensselaer County is a program of Healthy Families New York, funded by NYS Office of Children & Family Services.

MOMS Program - Located at Cohoes Family Care in Cohoes, the MOMS Program provides pregnant women with an array of non-medical services, including pregnancy health and childbirth education; social worker services (counseling and referral to community services); nutrition counseling; parenting education; family planning education; HIV counseling and confidential testing; bilingual education materials; early access to prenatal care, including free pregnancy testing, referral to an obstetrician, determination of Medicaid/WIC eligibility; referral to WIC, primary care and pediatric services; and assistance with public transportation. Services are free.

Sunnyview Rehabilitation Hospital

Nursing Home Transition and Diversion Medicaid Waiver Program - Sunnyview is a Regional Resource Development Center for the New York State Nursing Home Transition and Diversion Medicaid Waiver Program, under contract with the New York State Department of Health. The program provides individuals 18 years of age and older and a resident of a nursing home, or in need of nursing home level of care, the opportunity to live at home. Services are available in Albany, Columbia, Greene, Rensselaer, Schenectady and Schoharie counties and include independent living skills training; congregate and home-delivered meals; assistive/adaptive equipment; day services; home visits by medical personnel; home and community support services; and assistance with housing, moving, furnishings.

Low Vision Program - this specialized program helps individuals effectively use their remaining vision to maximize independence in daily life. Services are designed for people whose best-corrected vision does not permit reading or other visual activities without difficulty. Specially trained staff help evaluate safety and independence in the home; train patients to work with optical and non-optical devices, including electronic equipment such as closed-circuit televisions; and provide linkages to community resources.

V. Three-Year Plan of Action

A. Strategies for Selected Priorities

- **ALBANY MEMORIAL HOSPITAL**

1. Access to Care: Enhance Primary Care Services

Albany Memorial Hospital operates three of Northeast Health's eight physician practices within its Primary Care Network (PCN). Currently, the PCN is developing a new model of care based within the primary care office practice setting. This model is named Family Team Care (FTC) after the concept of Medical Homes. As a new model of care, our overall three year goal by Dec. 2012 is to implement this in at least two primary care sites.

FTC can be described as the appropriate distribution and delegation of tasks to trained individuals (physicians, extenders, nurses, social workers) or community public healthcare partners working together in a coordinated way, thus allowing the physician to spend more time on complex medical decision-making. The benefits to this model include more efficient office visits which ultimately result in enhanced patient care with faster access to care. Criteria used to select this as a priority area resulted from less-than-acceptable wait-times for patient appointments, as well as patient satisfaction levels.

2. Chronic Disease: Cardiovascular (CHF & Stroke)

- **CHF** - An estimated two to three million Americans are affected by congestive heart failure (CHF). It accounts for more than 750,000 hospital admissions annually, many of which are avoidable. The Heart Program at Albany Memorial Hospital is a comprehensive outpatient program for patients with CHF that features outpatient treatment in a supportive, friendly environment and provides an alternative to frequent hospitalizations. The goal of the program is to improve quality of life and promote independence with an emphasis on self-care. To insure that CHF patients receive coordinated care from diagnosis to day-to-day management of their condition, the care facilitator, a registered nurse, works with patients and their physician to manage the care at any one of our Northeast Health affiliates.

- **Stroke** - Studies show that when treated quickly, most stroke victims have a greater chance for full recovery. Albany Memorial Hospital is a designated primary stroke center by the New York State Department of Health. To maintain the stroke designation, the hospital must provide two community programs on cardiovascular issues annually, as well as two EMS programs on cardiovascular disease annually. In addition, Albany Memorial has developed a specialized Stroke Alert program ensure that stroke patients coming to the emergency department receive prompt coordinated stroke care and treatment during the acute, inpatient and recovery phases. Working in partnership with local ambulance personnel, a specialized stroke team is placed on alert in our emergency departments and is ready to assess a patient within 15 minutes of his or her arrival. For patients admitted to the hospital, our post-acute stroke team includes a physical therapist, speech therapist, occupational therapist, clinical resource managers and physicians.

Cardiovascular Disease Prevention - Overall three-year goals:

By December 2012 -

1. Provide six cardiovascular prevention presentations at community locations for an estimated 10 individuals per presentation.
2. Conduct six blood pressure screenings at community locations for an estimated 20 individuals per screening.

3. Participate in six community-based health information fairs with an estimated attendance of 100 individuals per event.
4. Provide six cardiovascular presentations targeted to professional EMS staff.

3. Chronic Disease: Diabetes

Albany Memorial's Diabetes Center is dedicated to helping individuals with diabetes improve their quality of life by providing education to patients and their families. A variety of self-management programs include monitoring blood sugar levels, balancing food, medication and exercise, managing and preventing the complications of diabetes, and dealing more effectively with stress. The hospital also offers specialized programs, such as gestational diabetes management and insulin pump therapy. The program is recognized by the American Diabetes Association.

The Diabetes Center is an active participant of the Greater Capital Region Coalition for Diabetes Prevention and Control, a multi-agency partnership serving Albany, Columbia, Greene, Rensselaer and Schenectady counties. The other organizations that the Albany Memorial's Diabetes Center partners with through this Coalition include:

- Ellis Hospital Center for Diabetes
- Healthcare Consortium of Columbia County
- Albany County Health Department
- Albany Medical Center Goodman Diabetes Services
- New York State Department of Health

The mission of the coalition is to improve the health and well-being of individuals at-risk or living with diabetes by facilitating high-quality diabetes care that includes education and prevention.

Diabetes Prevention - Overall three-year goals:

By December 2012 -

1. Provide six diabetes professional education presentations for an estimated 10 healthcare professionals per presentation.
2. Conduct six diabetes education events for an estimated 50 individuals per event.
3. Provide a monthly adult diabetes support group for an estimated 10 individuals per group.

• SAMARITAN HOSPITAL

1. Access to Care: Enhance Primary Care Services

Samaritan Hospital operates five of Northeast Health's eight physician practices within its Primary Care Network (PCN). Currently, the PCN is developing a new model of care based within the primary care office practice setting at South Troy Family Health Center. This model is named Family Team Care (FTC) after the concept of Medical Home. As a new model of care, our three year goal is to implement it in at least two more primary care sites.

FTC can be described as the appropriate distribution and delegation of tasks to trained individuals (internally and/or public healthcare partners) working together in a coordinated way, thus allowing the physician to spend more time on complex medical decision-making. The benefits of this model include more efficient office visits which ultimately result in enhanced patient care with faster access to care. Criteria used to select this as a priority area resulted from less-than-acceptable wait-times for patient appointments, as well as patient satisfaction levels.

2. Chronic Disease: Cancer (Breast and Colon)

Samaritan Hospital provides comprehensive cancer services through its Cancer Treatment Center, including: one centralized location for treatment and doctors' appointments, medical oncology/hematology and radiation oncology services, assistance with transportation, support for patients and families, and education/screenings.

Cancer Care & Prevention - Overall three-year goals:

Objective #1: To decrease the time spent waiting for a clinical diagnosis of breast cancer, specifically targeting the uninsured and underinsured populations.

Collaborators: Cancer Services Program, Primary Care Physicians, OB/GYN Physicians, Susan G. Komen.

Strategy: Implementation of “No More Sleepless Nights” initiative which will meet or exceed national benchmarks in: 1) The time from abnormal screening to diagnostic mammogram meets or exceeds national benchmark of 20 days to ensure timely diagnosis of breast cancer; 2.) Time from diagnostic mammogram to biopsy meets or exceeds national benchmark of 19 days to ensure timely diagnosis of breast cancer.

Measurement:

- Goal is to have 100% of patients seen in 10 business days for diagnostic mammogram.
- Goal is to have 100% of patients to biopsy in nine business days.
- We will serve 100 uninsured or underinsured patients each year.
- To provide two education programs per calendar year that reaches 100 individuals.

Expected Outcomes:

- Exceed national benchmark of 20 days to diagnostic mammogram.
- Exceed national benchmark of 19 business days to biopsy.
- Provide mammography services to at least 100 uninsured or underinsured individuals each year.

Objective #2: To increase the availability and accessibility of medical oncologists located at the Samaritan Hospital Cancer Treatment Center and adherence to quality oncological standards of care.

Collaborators: Primary Care Physicians, OB/GYN Physicians

Strategy: Recruitment of a second full time medical oncologist and implementation of quality measures to ensure adherence to national guidelines and patient-centered care.

Measurement:

- Recruitment of second medical oncologist by December 31, 2009.
- Adherence to quality measures in breast cancer, colorectal cancer and pain management.

Expected Outcomes

- 100% of eligible patients will be educated on chemotherapy regimen, side effects, medication and management to ensure patient centered care
- 100% of patients who are diagnosed with Stage III Colon Cancer will receive chemotherapy to ensure evidence-based guidelines are upheld.
- 100% of patients diagnosed with Stage IC - III, ER-PR+ Breast CA will be offered chemotherapy or hormonal therapy as specific for their particular diagnosis to ensure evidence-based guidelines are upheld
- 100% of patients receiving chemotherapy will be evaluated for pain and interventions documented at each and every chemotherapy infusion visit.

Objective #3: Implementation of two full time patient navigators to help patients and their families manage cancer diagnoses and overcome barriers to obtaining timely and appropriate cancer care and treatment.

Collaborators: Newman's Own Foundation; Private Grants and Individual Donors; American Cancer Society; Leukemia & Lymphoma Society; Albany Law School; Gilda's Club; To Life!
Strategy: Hiring and training of one additional full-time patient navigator who is an oncology certified nurse to add to the resources of the hub of the patient's cancer care team.

Measurement:

- Recruitment of one full-time patient navigator by December 31, 2011.
- Access to navigator and disease types as follows:
- 2010 - 100 patients navigated in the areas of breast, lung, colorectal and head and neck cancer
- 2011 - 175 patients navigated in the areas noted above with the addition of prostate as well
- 2012 - 250 patients navigated in all cancer diagnoses seen in the Cancer Treatment Center

Expected Outcomes

- Patient will have access to community resources specific to their disease.
- Time from pathological diagnoses to treatment decision will decrease from our current standard of 22 business days.
- Patient evaluation surveys will consistently rank in the top 90th percentile.

3. Mental Health & Substance Abuse

For nearly 30 years, Samaritan Hospital has served as a resource for individuals dealing with psychological, psychiatric and addiction challenges. Believing that everyone is entitled to respect, personal dignity and the opportunity to take an active part in their plan of care, programs provide a safe and secure environment to enhance the lives of thousands of individuals and families. By offering opportunities for independence and the skills needed to overcome the challenges of their illness, Samaritan can help to improve clients' productivity, self-esteem and satisfaction with life. Services include individual, couple and family counseling; crisis care; inpatient adult psychiatric; inpatient and outpatient mentally ill/chemically addicted MICA services; intensive day treatment.

Behavioral Health - Overall three-year goals

Suicide Prevention

County-wide objective -- Decrease # of suicides in Rensselaer County

-- Increase community awareness via education Measure = # of people educated

- Host/ Chair County-wide Suicide Prevention Task Force meeting monthly which includes representatives of Police, the Medical Examiner, Education, Consumers, American Foundation for Suicide Prevention, County Mental Health Commissioner, Unity House, Northeast Career Planning, Troy Housing Authority, Mental Health Empowerment Project, and other Behavioral Health professionals.

Hold monthly Task Force meetings

- Depression Screening Site - October each year

Hold 1 free screening per year at Samaritan

- SAFETalk and ASSIST training programs to create a "suicide safer" community where community gatekeepers (not mental health professionals) are trained to recognize warning signs and provide linkage to support

Hold 2 of each program per year. Train 25 persons per program

- Primary Care Physician training regarding Suicide Prevention
- Train 100% of the physicians working in the primary care sites via one annual program

Education

- Continued partnership with Police Department with the Emotionally Disturbed Persons Response Team, primary trainers in Mental Health

Hold 2 classes per year (One basic, one advanced class) open to law enforcement, security officers, corrections officers and parole officers reaching at least 30 new persons

- Primary Care Education (see above)
- Patient education re: early mortality for patient's with mental illness

Insure that patients are educated on early mortality through their counseling sessions
Include wellness components in these sessions

- Implementation of new Office of Mental Health initiative in Wellness Self Management - Provide education to other community mental health providers

OMH reports will track progress on implementation of their wellness program - a group based model

Educate at least five other community mental health providers

SUNNYVIEW REHABILITATION HOSPITAL

Access to Care: Enhance Rehabilitative Care Services

Sunnyview Rehabilitation Hospital and Schenectady County Public Health Services identified the current programs that address these issues and created the following plan of action for utilizing existing programs for creating new initiatives to address them. A set of measurable outcomes for each priority area has been developed and will be tracked through regular meetings between Sunnyview and SCPHS, and their community partners as applicable.

1. Sunnyview Rehabilitation Hospital employs thirteen (13) Registered Nurses as Patient Admissions Liaisons (PALs). These individuals regularly visit all Capital District acute care hospitals to evaluate patients in need of rehabilitation for potential admission to Sunnyview and to arrange for their expeditious transfer to the most appropriate level of care.

- a. Track the number of inpatient, outpatient and psychiatry outpatient visits for patients from Schenectady County – Goal to meet or exceed 2009 total number of visits
- b. Track onset days for inpatient admissions to show ready access to the correct level of care with timely transition from the acute med/surg hospital.
Goal – Meet or exceed facility average of 11.55 days

2. Sunnyview Rehabilitation Hospital has created a Patient Needs Scholarship, funded largely by employee contributions. These monies are awarded to patients to defray costs of needed medical rehabilitation services for which they do not have insurance coverage. The scholarship is based on financial need.

Number of patient need scholarships awarded - \$72,030 awarded in 2008, forecast \$84,600 in 2009

- a. Total amount of dollars awarded for services will meet or exceed 2009 forecast
- b. How many dollars were awarded to provide bariatric patients membership to the Lifestyles Wellness Center; combined wellness membership and pool group - \$3595 in 2008, forecast \$3550 in 2009 – Goal to meet or exceed 2009 forecast

3. Sunnyview has acquired specialized bariatric equipment, inclusive of beds, commodes, wheelchairs and specialty exercise equipment. This has allowed us to serve the clinical bariatric patients in both the inpatient and outpatient settings.

4. Sunnyview has acquired specialized low-speed treadmills and installed wall oxygen in the Lifestyle Wellness Center to allow patients with significant cardiac or pulmonary limitations to actively exercise in a supervised setting to improve their overall health.

5. All patients discharged from Sunnyview inpatient and/or outpatient programs are given a complimentary 1-month membership to the Lifestyles Wellness Center. This includes three (3) instructional sessions with a certified personal trainer.

- a. Number of “free months” at the Lifestyles Wellness Center given to former patients
- b. Number of “free months” that translate into regular membership.

Chronic Disease: Diabetes & Obesity

HEALTH CARE PRIORITY #2: Chronic Diseases – Focus on Diabetes & Obesity

1. See Item #3 above.
2. Sunnyview has worked collaboratively with the bariatric program surgeons at Ellis Hospital to better meet the full constellation of preoperative and postoperative needs of the bariatric patient. All patients are oriented to the Lifestyle Wellness Center gym, inclusive of the therapeutic pool, before their surgery is scheduled. Certified Personal Trainers assist the patient to design a customized fitness/wellness program both preoperatively and post-operatively and encourage them to participate. The presence of a supportive and supervised gym environment in which to work out helps promote weight loss (directly associated with improved glucose control), preservation of lean and/or increase in muscle mass, and help to prevent development of osteoporosis in these patients.
 - a. Number of evaluations provided to preoperative and postoperative bariatric patients.
 - b. Number of memberships purchased by bariatric surgical patients.
 - i. Eight (8) memberships in 2008, Nine (9) memberships in 2009 – Goal to meet or exceed 2009 total number of memberships
 - ii. Eleven (11) Pool participants in 2008, Twenty-six (26) Pool participants in 2009 – Goal to meet or exceed 2009 total participants
 - c. Using the swiping system for entrance to the Lifestyles Wellness Center, track the number of visits for the bariatric population.
 - d. Consider rewards system with threshold for exceeding a number of visits per month, weight loss, etc.

3. Patients have been admitted to an inpatient acute rehabilitation program as needed and as third party payer funding allows, preoperatively for a 10-14 day conditioning program to decrease the operative risk. For very obese patients, a postoperative stay in inpatient acute rehabilitation to promote increased independence in ADL's and mobility is also possible, again within the constraints of the patient's funding source.

4. Sunnyview offers education regarding obesity and its associated comorbidities. The 2009 Robert S. Hoffman Lecture will address various aspects of stroke diagnosis, treatment and recovery and will also review the need to control those risk factors under the individual's control. Emphasis will be placed on the need to achieve and maintain an ideal body weight. Additionally, the patient education of all inpatient programs reinforces the benefits of risk factor reduction and the benefits of having a healthy Body Mass Index (BMI).

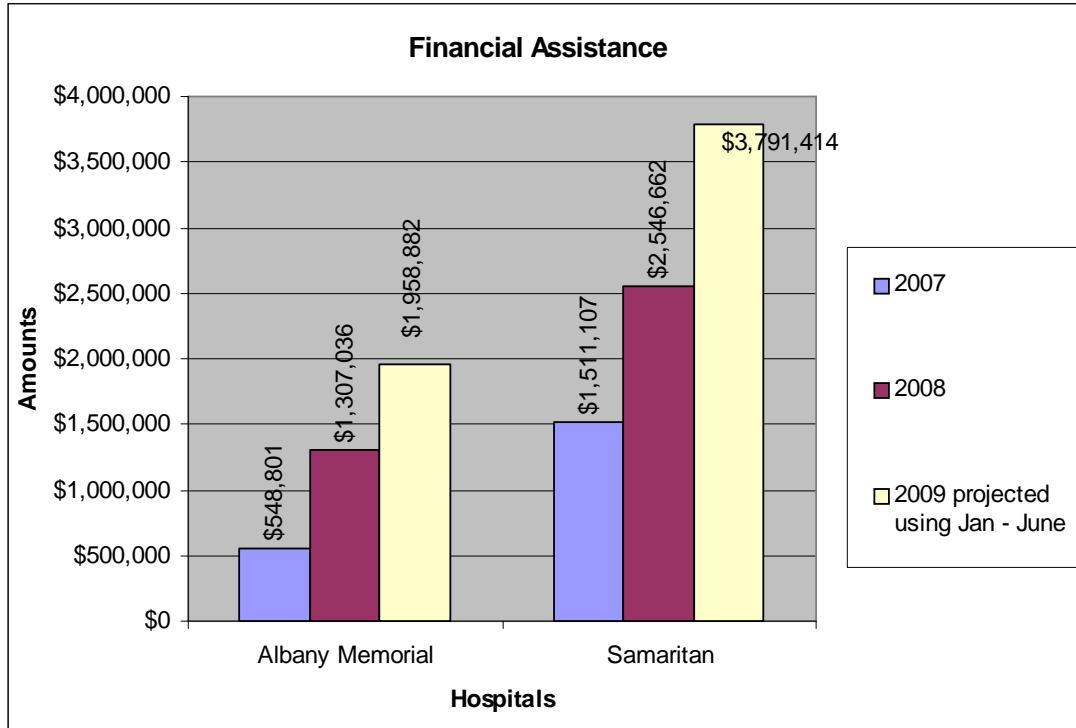
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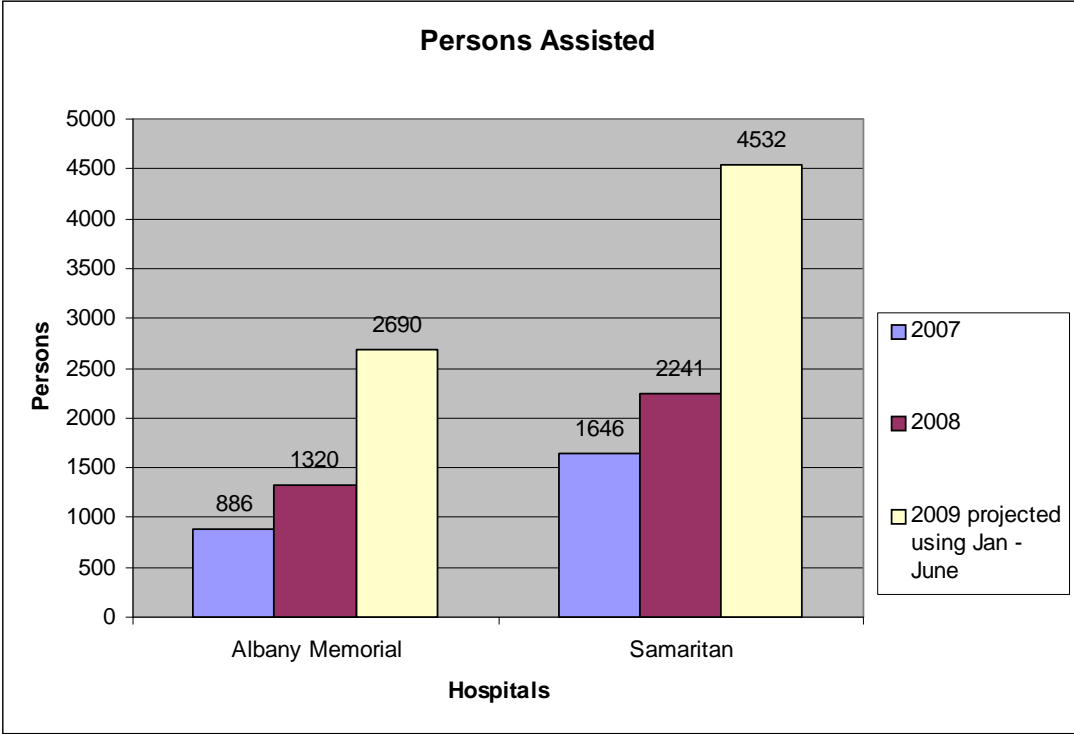
VI. Financial Aid Program

As required by Public Health Law, each of our institutions is committed to providing financial aid. The changing economic climate has made that a more important commitment to insure access to care and a more challenging commitment because of the declining public resource available to pay for care.

Challenges

It is impossible to tell this story without referring to our financial information. This is the past 2 ½ year history of our financial aid profile. (Actual data through June 2009)





For all of our acute general hospitals, our commitment and dollar value of financial assistance has increased dramatically in 3 years, doubling at Samaritan, for example.

This is the most significant challenge. The volume of applicants and the amount of resources used reflect the growing need to address the health insurance, unemployment and related gaps in our community.

Successes

In order to make our program easier to understand, easier to apply and more accessible to those in need, we implemented these changes.

Simplification of the application for reduced payment for outpatient services

Our application was revised and simplified. It is now a one-page application with a one-page attachment which identifies sources of income and special circumstances that contribute to the reduced ability to pay. No supporting information is required to verify income.

Shortened turnaround time

The hospitals now agree to a 30-day final determination from the receipt of a completed application. All requirements to pay are omitted during the processing time.

Decentralized application processing

Currently these applications can be processed at the primary care sites for those clients. This eliminates the need for the application to be reviewed by the business office.

Same day processing of ED applications

We also seek to complete the application process for ED patients on the day that they are discharged. To date we are able to do this for 60% of the applicants.

Financial assistance at Sunnyview is also a significant commitment. In 2008 Sunnyview provided \$556,000 in charity care.

VII. Changes Impacting Community Health / Provision of Charity Care / Access to Services

In February 2009, Northeast Health and St. Peter's Health Care Services announced an agreement to enter formal negotiations intended to lead to an affiliation of the two organizations. Additionally, Seton Health has initiated formal negotiations with Northeast Health and St. Peter's to actively pursue a similar legal agreement. Expanding negotiations to all three systems greatly enhances the opportunities to strengthen the delivery of healthcare in our communities and achieve the unified goals of affiliation.

Very simply, the intention of entering these negotiations is to explore healthcare reform at the local level – to improve when, where, and how care is provided. Through an affiliation, the hospitals will be able to develop collaborative ways to deliver healthcare in a more coordinated, seamless fashion and improve efficiency and reduce fragmentation of care.

Although Northeast Health will continue to be a secular organization, the hospitals will abide by the Ethical and Religious Directives (ERDs) as developed by the Catholic Church. Although

adherence to the ERDs is already consistent with most practices and services at Northeast, Samaritan will not continue to provide certain reproductive procedures. To ensure these services continue to be provided, prior to formal affiliation, Northeast will help create a separate healthcare entity at Samaritan Hospital. The new entity will become a separately licensed, independent organization governed by its own board and with its own identity. The new entity will offer prenatal care, birthing and sterilization procedures (tubal ligations and vasectomies), retaining these services at their current location and supported by the same physician practitioners. Samaritan and Albany Memorial hospitals do perform a small number of abortions annually that they will no longer provide. Northeast officials stand ready to consult and work with other healthcare providers in Rensselaer and Albany counties to ensure there is capacity to respond to this community need at other locations

At this point, the hospitals are involved in a process of due diligence to review clinical, financial, governance, regulatory, cultural and administrative issues. We expect the initial phase to be completed sometime in 2010.

VIII. Dissemination of the Report to the Public

1. Plans call for an abbreviated written summary of the CSP to be produced and made available to the public through distribution in hospital waiting rooms/lobbies and throughout the PCN.
2. The CSP in its entirety will be posted on the hospitals' website:
www.NortheastHealth.com
3. The hospitals provide ongoing communication to the public regarding public health programs and financial assistance programs through newsletters, press releases, feature stories, speaking engagements at community organizations, via posters, flyers and a consumer web site.